Centers for Medicare & Medicaid Services
Physician Quality Reporting System and Electronic Prescribing Incentive Program
Electronic Health Record and Registry-Based Reporting Options
National Provider Call
Moderator: Geanelle Herring
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Contents

Holley: At this time, I would like to welcome everyone to the Physician Quality Reporting System and Electronic Prescribing National Provider Call on Electronic Health Record (EHR) and Registry-Based Reporting Options conference.

All lines will remain in a listen-only mode until the question and answer session. This call is being recorded and transcribed. If anyone has any objection, you may disconnect at this time.

Thank you for your participation in today's call. I will now turn the call over to Geanelle Herring. Thank you, ma'am. You may begin.

Introduction

Geanelle Herring: Thank you, Holley.

Hello, everyone, and welcome to the final National Provider Call for calendar year 2011. Our calls for 2012 will resume in January. As stated earlier, my name is Geanelle Griffith Herring, and I will serve as your moderator.

Following a few brief announcements and a presentation that will provide an overview of the Electronic Health Records (EHR) and registry-based reporting options, the phone lines will be open to allow you to ask questions of CMS subject-matter experts.

With me today are those subject matter experts who have been instrumental in the development of policies, procedures, measures, and specification guidelines, as well as all other aspects of both programs. I will now turn the call over to Dr. Michael Rapp.

Updates

Michael Rapp: Thank you, Geanelle.

I'm Michael Rapp. I'm the director of the Quality Measurement and Health Assessment Group that serves as the lead for the Physician Quality Reporting System and the Electronic Prescribing Incentive Program here at CMS. I'd

like to welcome you all to the call today. We do appreciate your continued interest in the Physician Quality Reporting System and the e-Prescribing Incentive Program. And we will today provide an overview on the EHR and registry-based reporting options available for eligible professionals who are or will be participating in either the Physician Quality Reporting System or the electronic prescribing program.

In order to make sure folks have plenty of time for questions, I'm going to limit my remarks and turn the meeting over to Lauren Fuentes for some announcements.

Lauren Fuentes: Thank you, Dr. Rapp.

I would just like to take this opportunity to provide a few updates around the 2012 e-prescribing payment adjustment. First, I just wanted to provide some clarification around some recent correspondence eligible professionals may have received from CMS.

Earlier this month, CMS sent out e-mail notifications to some eligible professionals who submitted one or more requests for a significant hardship exemption from the 2012 eRx payment adjustment. This e-mail stated, "This formal notification is to inform you that the 2012 e-prescribing payment adjustment, which will result in a 1 percent reduction on an eligible professional's 2012 Medicare Part B physician fee schedule covered professional services, does not apply to you based on the identifying information received in your hardship request. Therefore, your request for a significant hardship exemption to the 2012 e-prescribing payment adjustment will be disregarded."

We've received several questions through our QualityNet help desk about this e-mail and I just wanted to provide some clarification that this e-mail was sent to those individuals who, based on the identifying information they entered in the communications support page, were found not to be subject to the 2012 e-prescribing payment adjustment. In other words, the individual TIN/NPI combination that was submitted with the hardship exemption request did not

match any TIN/NPI combination for individuals who are otherwise subject to the 2012 e-prescribing payment adjustment.

Also, we would like to provide an update regarding the 2012 e-prescribing payment adjustment feedback report. Due to a variety of reasons, it is no longer technically feasible for CMS to provide a 2012 e-prescribing payment adjustment feedback report as originally intended. As we continue to explore alternative means to notify eligible professionals that they are subject to the 2012 e-prescribing payment adjustment, we urge you to review your remittance advices for claims submitted for dates of services on or after January 1, 2012.

Eligible professionals and group practices participating in the eRx GPRO that received the 2012 e-prescribing payment adjustment will see the term “LE” on their remittance advice for all Medicare Part B services rendered January 1 through December 31, 2012.

The remittance advice will also contain claim adjustment reason codes and remittance advice remark codes. If an eligible professional or group practice that participated in the eRx GPRO receives the payment adjustment in error — for example, if the eligible professional or group practice submitted a hardship exemption request that is ultimately approved by CMS — please be advised that the claim will be reprocessed to return the 1 percent.

For more information on how the 2012 e-prescribing payment adjustment will be assessed and applied, please refer to the MLN matters article, special edition 1141, which can be found on the educational resources page of the e-prescribing incentive program Web site at http://www.cms.gov/erxincentive.

That concludes our updates on the 2012 payment adjustment, and I will now turn the call over to Diane Stern.

Announcements and Reminders

Diane Stern: Thanks, Lauren.

The Centers for Medicare and Medicaid Services would like to announce that, on November 1, 2011, CMS issued a final rule with comment period updates to the payment policy's rates for physician and non-physician practitioners for services paid under the Medicare physician fee schedule during the 2012 calendar year. This rule includes updates to the 2012 Physician Quality Reporting System, as well as provisions for the 2012, 2013, and 2014 Electronic Prescribing Incentive Program.

The final rule with the comment period went on display in the November 28, 2011, Federal Register. CMS will accept comments through January 3, 2012. This final rule can be viewed at http://www.cms.hhs.gov/pqrs on the Statute Regulations Program Instructions section page by clicking on the link titled "2012 PFS Final Rule-CMS-1524-FC" and the Related Links Outside of CMS section.

The 2011 qualified Electronic Health Record vendors list has been updated and posted on the Alternative Reporting Mechanisms Section page of the PQRS Web site.

I would like to give you some reminders. We would like to remind eligible professionals that it's not too late to participate in the 2011 e-Prescribing Incentive Program to potentially qualify for a 2012 e-prescribing incentive and be excluded from the 2011 e-prescribing payment adjustment. Eligible professionals have until December 31, 2011, to meet the requirements for the 2011 incentive and thus be excluded from the 2013 payment adjustment.

The deadline to get self-nomination letters in from qualified entities for participating in the Physician Quality Reporting System and e-prescribing 2012 program year is January 31, 2012. This applies to large and small group practices seeking qualification for 2012 Physician Quality Reporting System and e-prescribing; registry-seeking qualifications for 2012 Physician Quality Reporting System and e-prescribing; EHR vendors and EHR data submission

vendors seeking qualifications for 2012 and 2013 Physician Quality Reporting System, Physician Quality Reporting System EHR incentive program pilot participation, and e-prescribing; and maintenance of certification program incentive entities seeking qualification.

We would like to continue to remind everyone that the CMS Web site is the primary and authoritative source for all publicly available information, and CMS supported educational implementation support materials for both the Physician Quality Reporting System and the e-Prescribing Incentive Program. Measure specifications and related materials are updated each program year. It is your responsibility — the participant, not CMS — to ensure you are using the current year materials as codes and requirements could change from one program year to the next.

Always reference the current year documents. 2012 measure specification materials have been posted to the Physician Quality Reporting System and e-Prescribing Incentive Program Web site. Review the spotlight page on both Web sites to see what documents have been posted. Our next National Provider Call is scheduled for January 17, 2012, to begin at 1:30 and run until 3:00 p.m. Eastern Standard Time.

I will now turn the call over to Dr. Daniel Green, who will be presenting on EHR and registry-based reporting options.

Registry Reporting of 2011 Data

Daniel Green: Thanks, Diane.

Welcome, everybody, to today's call. Thank you for taking time out of your busy schedules to dial in today, and I want to wish everybody a happy, healthy, and safe holiday season.

You can find the slides that I'll be speaking from on our PQRS Web site. We're going to start today on slide number 3 where it discusses the agenda for today. Basically, we're going to talk about how folks can report via our

registry for 2011; or if they have a qualified EHR, how they could report directly from their EHR for the 2011 program year.

Additionally, Kim Schwartz will be providing some information about how folks can obtain their IACS accounts, which would be necessary if you plan to report directly from your EHR. Finally, of course, there will be time for questions and answers at the end of the presentation.

Moving ahead to slide number 5, as Diane mentioned, there is still time to report in 2011. You can report in the Physician Quality Reporting program, or PQRS, and/or the e-Prescribing Incentive Program. Ways to do this at this point would include through a qualified registry or via a qualified EHR, if you're using one in your office.

You could essentially qualify for a full year's reporting incentive payment by doing either of these methods and/or by using claims if you think you received 30 patients that would fit into a qualified measures group between now and the end of the year.

Moving on to slide 6, let's talk about a registry for a moment. We define a registry as a vendor or entity that captures and stores data that's clinically related to quality actions that folks are performing in their office. These vendors, if you will, also submit data on behalf of their eligible professionals to CMS for PQRS. We select qualified registries annually. And basically, how we select these folks is, they self-nominate to participate in the program, and we put them through a vetting process to ensure that they're able to submit their data in the proper format to CMS.

Despite the fact that we go through this vetting process, CMS cannot guarantee that each vendor will be successful in submitting their data. We've been fortunate to this point. We've been using the registry since 2008, and every registry that is intended to submit information has been successful getting that information into CMS to this point.

The registry reporting is the only method in PQRS that actually provides calculated reporting and performance rates to us. As you know, from claims

we're getting individual-level data and we calculate the measures, and that's true also for Electronic Health Records. We're getting individual data elements and calculating the results.

From a registry, the data has to be submitted via a defined XML specification that CMS and its contractors have developed for PQRS. In claim space measures specifications, there are both individual and measure group specifications. When we're talking about qualified registries, eligible professionals who wish to report to PQRS using this method of submission have to select a qualified PQRS registry. This list can be found at http://www.cms.gov/pqrs.

If you look in the downloads section, the 2011 qualified registry posting dated November 30, 2011, can be found on the alternative reporting tab on the PQRS Web page. So we would encourage you — if you're interested in registry reporting and you haven't selected a registry to this point — to review that list and find a registry that you think would meet your needs and then contact the registry.

As I mentioned earlier, each of these registries has gone through a vetting process that included checking their capability to provide the required data elements, reviewing measure flows and algorithms and/or use cases so that we could help to ensure that their calculations for the data that they provide us are done correctly and accurately so we can pay the eligible professional appropriately. Also, we test that this information can be transmitted in the required XML format. That information you can see, including the Web link, on slide 7 of the presentation.

Moving on to slide 8, we want to talk about some of the methods that registries use to collect their data. This would include copy of claims, so there are some registries out there that actually ask their eligible professionals to send them a copy of the claim that they have, the appended G-code, or CPP2 code. Some registries have their eligible professionals actually log in to a Web site and the eligible professionals will take their records and enter the data for a given patient through the Web portal to the registry.

If they're doing a diabetes measure, for example, they would enter all of their diabetic patients through the Web portal in this manner for the registry to collect and calculate the information.

Some registries have access to eligible professionals practice management software, their billing software. Those registries can data-mine the denominator-eligible population from the eligible professional system, and then they can give, if you will, the eligible professional a list of the patients that they need to provide information or the numerator data — in other words, the quality action data to the registry.

Finally, some registries actually are EHR vendors, and they're able to data-mine the eligible professional system to actually collect both numerator and denominator information.

Moving on to slide 9, the registries submit 2011 data on behalf of their eligible professionals in the first quarter of 2012. It starts about February 1, and they have until the end of March to submit that data. So some registries allow eligible professionals to actually sign up with them in late December or sometimes even early January. Because it's not associated with claims in terms of submitting claims to CMS, the eligible professional can upload their data even though the year has passed, which enables folks again to report a little bit later.

We would encourage you guys to work with your respective registry on the specifics in terms of what they permit or don't permit; and again, a list of the registries can be found on our Web page.

Moving on to slide 10, the requirements for reporting via registry in 2011: An eligible professional has to report on at least three individual measures or at least one measures group. Again, there's more information about this on our Web site.

There's a 2011 Physician Quality Reporting measure list, which has the specifications and release notes for the individual measures, and there's also

similarly a document that discusses the measures groups, the specifications, and release notes for that, as well.

Moving on to slide 11, we talk a little bit about measures groups. A measures group basically is a group of measures that has four or more measures that are related to a clinical topic. They have a common patient population, so the denominators of these measures have typically been harmonized so that an eligible professional can report on multiple measures on the same patient.

It's important to note, though, that the measures group specifications are not necessarily the same as those for individual measures. In an effort to form the measures groups, as I mentioned, sometimes we have to modify the denominator. So if a measure says report for patients 18 through 75, it may be, such as is in the preventive measures group, that we change that to, say, patients 50 to 75. In other words, we made the lower age limit 50 so that eligible professionals would be able to report more measures on that given patient. Please do check the measures groups specifications if you are intending to report via measures group.

The reporting period that is available through registries is a full-year, 12-month reporting period that starts January 1 and ends December 31 of 2011. Then we have a 6-month reporting period that starts July 1 and ends December 31. If you report under the 6-month reporting period, you basically would be eligible if you're successful for a half-year bonus incentive.

Some of the reporting methods and options that are available are claims and registry. If you're reporting measures groups, you have to report on a minimum of 30 patients or 80 percent of your patient sample. So if you're reporting via registry, and you're doing the diabetes measures group, you have to report on 30 Medicare diabetic patients. They don't have to be consecutive, but they do all have to be Medicare, and we do require 30 patients.

You might say, "I don't have 30 patients that have diabetes in my practice." Well, we do allow you to report on 80 percent of the folks that would fall into that measures group, subject to a minimum of 15 for the full-year reporting or 8 for the 6-month reporting option.

There is an Appendix C decision tree in the 2011 Physician Quality Reporting implementation guide. It's a really nice chart that helps folks decide what would be the most appropriate method for them to report in. If you have questions, that would be the first place I would start.

Step one for registry reporting: You want to determine whether or not you're eligible to participate in the Physician Quality Reporting System. You can see a list of professionals who are eligible and able to receive an incentive for participating in PQRS by looking on our Web site. It's under the PQRS 01 overview. Again, the Web link is on slide 12 in the presentation today.

You can also see a list of professionals who are eligible and able to receive an incentive in the eRx program. Again, that Web link is in the slide, so I'm not going to take time to review it right now.

Step two for registry reporting, which can be seen on slide 13, is to determine which registry reporting option best fits your practice. So for individual measures or measures groups, do you want to do the 12-month reporting or the 6-month reporting? Again, that's going to vary a little bit on whether you can. For instance, we don't have 6-month individual reporting through registries; but we *do* have for measures *groups* through registries for six months. Of course, you could do the 12 months individual measures or measures group. Again, that decision tree that I had mentioned earlier would be a great place for you to start looking.

In fact, on slide 14, you'll see a copy of that decision tree. Basically, at the top it says, "You want to participate in 2011, PQRS for incentive payment." What's highlighted is choosing the registry-based reporting option. Then, of course, three or more measures have to apply to your practice. Then it flows down and you can read the specific options that are available to you on that decision tree.

Moving on to slide 15, step number three for registry reporting: You want to determine which measures are going to apply. So again, if you're doing individual measures, you want to pick out at least three measures. If you

choose to report a measures group, obviously you can select one measures group. And we do have many measures groups available in 2011 that cover a broad array of disease topics that, hopefully, one of which will apply to your practice.

On slide 16, review the documentation, which is step four. Once you've selected the measures, again, at least three, you want to review the measure specifications manual if you're doing individual measures, or the measure group specification manual if you're doing measures groups. You want to review the 2011 PQRS implementation guide. Especially if you were going to be using claims, you'd want to look at that because there is a copy of a claim in there which shows you how to fill the information out. Again, both of these are available as downloads on our PQRS Web site.

Again, if you're doing the measures groups, as you can see on slide 17, remember to check the measures group specifications, because these do differ slightly from the individual measures in several instances. Again, there's an implementation guide for getting started with measures groups. If you're doing the measures groups reporting, we would encourage you to look at that. There is also a 2011 Physician Quality Reporting fact sheet, "Physician Quality Reporting Made Simple for Reporting the Preventive Measures Group."

This was an ingenious creation by one of our medical officers a few years ago to try to simplify the process for reporting measures groups. One of the nice things about this is preventive measures groups, which is one of the measures groups where not all of the measures actually apply to a given patient. For instance, male patients, obviously we don't expect you to report a mammography measure. So this kind of breaks out which measures would be applicable to a given patient based on their age and gender.

If you look on slide 18, step five, the final step would be to find a qualified registry that's able to submit the measures information that you want to submit. Again, the registry list is available on our alternative reporting mechanism tab on the PQRS Web site. It's a download there.

What's important there is we'll have the name of the registry, whether they're open to new clients, the measures that they are planning to report or are able and qualified to report, and/or the measures groups that they are qualified to report.

If you decide you want to do the diabetes measures group, for instance, you'd want to find a registry that's open to new clients and that is reporting the diabetes measures group. You would then want to contact the registry and inquire about certain deadlines, how they collect their information, if there are any costs associated with it, and so on.

Looking at slide 19, switching to eRx, if you look at the 2011 eRx measures specification and release notes, that's on our eRx incentive Web site, which is www.cms.gov/erxincentive. Then from that main page, you can find the different sections of downloads. Again, there will also be a list of qualified registries there, as well.

On slide 20, you see some of the references that we've provided for you, so we have a whole bunch of information about registry reporting and PQRS in general, and we would encourage you to review these documents. Certainly, if you have specific questions, feel free to reach out to our QualityNet help desk and we'll give you that information at the end of the presentation.

Moving on to slide 21, this is just a quick overview of some of the numbers. In 2008, when we started registry reporting, we had 32 qualified registries; 31 decided to submit and were successful in submitting data on behalf of eligible professionals. We see that number grew to over 70 in 2009. And in 2010, we were up to 97.

We had over 12,000 participants in 2008, which more than doubled for 2009; we were over 30,000. And in 2010, we were over 50,000 eligible professionals. We had some preliminary numbers in our call yesterday. I'm pleased to report those numbers will be going up even further for 2011, at least as planned by the registries.

The other thing to point out, whereas in PQRS initially, folks were roughly in the upper 50 percent incentive eligible to report through claims; that number has grown into the 70s now. Through registry reporting, we're in the low 90s of folks being incentive eligible by reporting through a registry. So it is a nice option for folks to look at, particularly if you're coming to the table a little bit late and haven't been reporting on claims throughout the year.
In 2011, we still have 97 qualified registries. There are 27 qualified EHR vendors. Again, that list is posted on our alternative reporting mechanism page.

EHR Submission of 2011 Data

Moving on to slide 24, we will now switch gears a little bit to move from registry submission to EHR submission. And basically, we talked about what an EHR is here, and that's a systemic collection of electronic health information about individual patients or populations. The record is in a digital format and hopefully can be shared across different health care settings. That talks a bit about interoperability and things that the Office of the National Coordinator has mandated in the HITECH program.

We select "qualified EHR vendors" annually. And again, it's the same process as registries. These folks self-nominate and go through a testing process. And we qualify a specific product and version.

The file that they have to send in, instead of a simple XML, is a QRDA, a quality reporting data architecture. It's a subset of the HL7 CVA, which is a standard messaging that's used between computers for health information, and that's the way we collect the information from Electronic Health Records. So using a qualified EHR-eligible professional, submit raw clinical data to CMS, and we calculate the measures.

We're on slide 25 now — determining eligibility, you have to be able to report at least three of the EHR measures to be eligible for the incentive program. In 2011, there are 20 e-specified measures, so we would encourage you to look to see which of the EHR measure specifications to make sure that three of those measures are measures that you can and want to report to CMS.

If you wanted to report a measure that is not electronically specified, you couldn't report directly from your Electronic Health Record.

You also need to determine if the product you're using in your office is a 2011 PQRS-qualified EHR system. And, again, we have a list on our alternative reporting mechanism tab on the PQRS Web site. So if you're using AVC system version 2.0, you would want to look on our Web site to make sure AVC version 2.0 is a qualified system. If you're using AVC version 1.0 and that is not listed, that is not a qualified system that's been tested. So please be careful when you're checking to ensure that your system is, in fact, qualified.

Moving on to slide 26, again this just talks about the vetting process that the EHR vendors have gone through and, again, while we've made every effort here at CMS to ensure that the EHR vendors' product will be successful at getting this information to us, obviously CMS cannot guarantee that.

Moving on to slide 27, some EHRs are also capable of reporting the eRx, the electronic prescribing measure, to CMS. Again, you can see those vendors by looking at the alternative reporting mechanism tab on the PQRS Web site.

Again, the EHR-based reporting of the 2011 eRx measure only applies to the incentive. Remember, to avoid the 2012 payment adjustment, you had to send in 10 eRx events via claims in the first six months of this year. So this would be only for reporting the 25 e-prescribing events, which could conceivably earn you an incentive payment for the 2011 program and also would preclude you from being subject to the payment adjustment in 2013.

Again, more information can be found on the eRx incentive Web site, and we would encourage you to review that. There's a link on the bottom of slide 27.

Looking at slide 28, it just talks about the qualified vendor product and the required data elements for measure calculations. These qualified vendors, again, can report the required information to us to be able to calculate the measures in the requested file format, which is that QRDA I mentioned earlier.

If you see that you're using a qualified EHR and you're interested in the EHR submission method, we encourage you to contact your vendor. There is contact information — I'm sure you have it anyway — but there is contact information listed on the list of qualified EHR vendors on our Web site, and they can provide you more information.

Again, if you have a qualified system and you choose to do so, you can submit this information directly from your EHR system into our PQRS portal. You will need an IACS account, which is an identification system that we use here at CMS. In just a couple of minutes, Kim is going to be talking about how to obtain an IACS account.

Slide 29 is the disclaimer that I mentioned; despite our testing, we can't guarantee that a qualified system will be able to get the information in properly.

And then slide 30, you've heard me mention and talk about qualified EHRs. I'm sure you've also heard, through the meaningful use program or EHR incentive program, about how ONC has a "certified system." So PQRS qualification and ONC certification are two different requirements. ONC certification has a list of functionalities that an EHR has to do to become "ONC-certified." For PQRS-qualified, we have – I don't want to say a different list of functionality — but the one functionality that we do have is that the system is able to collect our 20 e-specified measures and submit the clinical data elements to us in the specified format. So please don't confuse the two terms when you're looking at these materials.

Moving on to slide number 31, in 2010 we had seven EHR vendors that were qualified to submit 2010 PQRS data. One vendor system did send in data to us. There were 15 eligible professionals who submitted directly from their EHRs, and 14 of these folks were incentive-eligible.

I know it doesn't sound like a tremendous number, but we were pretty excited here, because it was a very good proof of concept for us that we were able not only to receive the data, but parse the data into the appropriate buckets and calculate the measures based on this. So this is a first step in being able to

accept clinical quality data from Electronic Health Records, which we hope in the future will reduce the burden on eligible professionals and encourage them to be able to report into our quality programs more seamlessly.

Looking at slide 32, you can see some of the advantages of Electronic Health Records. We get primary source data, so we're not relying on a human, if you will, to data extract from a paper chart and then enter it into another system. This is primary source data.

Again, we'll have a little bit more reliable data, which is useful when we move to pay-for-performance programs, but will also be useful in public reporting. The data in the future could be more easily used for research, and it does allow us to look at more complex measures, both over a longer timeframe and measures that require additional calculations that would be cumbersome if an eligible professional were trying to report them via claims.

You can also look at outcomes measures versus process measures, so it may help us to identify best practices — the best way to treat certain conditions. As we move forward and become more sophisticated in the paper performance, this may even perhaps allow us to risk adjust the data.

So if you look at slide 33, there's that decision tree that's coming back.

But anyway, this talks about EHR-based reporting, and the key thing here is, 3 of the 20 e-specified measures for 2011 have to apply to your practice. Not every measure is electronically specified at this time, but steps for EHR-based reporting you can see on slide 34. You would need to register for an IACS account. The new user registration begins at the Web site, https://applications.cms.hhs.gov, and you'd have to request the EHR submitter role when registering for the IACS account. If you already have an IACS account, you'll need to request adding the submitter role to your account.

And then we would ask you to refer to the IACS EHR submitted role, quick reference guide, which is posted on our physician and other health care professionals' quality reporting portal homepage. Kim, as I mentioned, is going to talk more about the IACS account in just a second.

On slide 35, you can see that step two — this is just a reminder — there has to be at least three applicable measures for your practice, and you have to have a qualified EHR system, so it has to be by vendor and the actual specific version. Be sure to carefully review the 2011 Physician Quality Reporting System EHR measure specifications, and again, you can see that there's a link on slide 35 that could get you there. And it is on our PQRS Web site. There are also the release notes there, which we would encourage you to review.

Step three would be to work with your 2011 PQRS-qualified EHR vendor to create the required reporting file from your EHR. If you're using a qualified system, it's likely already programmed with the ability to generate this file. But, again, you would want to have a discussion with your vendor to help facilitate this process.

Step number four, you'd want to submit your final EHR files with the quality measure data during the submission period, which is the first quarter of 2012. The submission portlet can be accessed via the portal, which is https://qualitynet.org/pqrs, and this is how you would upload your files, which are created from your Electronic Health Record system. The specific submission dates will be announced on the January provider call. They will include the month of February and most likely into March.

Step number five on slide 38: Upload the files to the portal. You'd log in to the portal using your IACS account login information. You would choose the EHR submission link, indicate that it is a payment file, and upload your EHR files. It's important to note that the file upload size is limited to 10 megabytes. So you may have to upload several files to the portal.

Following a successful file upload, you will receive notification to your e-mail address indicating that the files were submitted and received. This basically means that they came in, in the proper format. It doesn't check for the particular data on this, but it says that we did get it in the proper format.

On slide 39, you can see step number six. There are additional references for the PQRS reporting eRx system submission user guide for further detailed information. There are also user guides on the qualitynet.org Web site.

Step seven, EHR submission reports will be available for your review via the portal to determine if there are any data submission issues, in which case you would need to work with your vendor to try to rectify these problems.

Looking on slide 40, you can see we have a list of references, and I would encourage you guys again, if you are going to participate in the program directly from your EHR, please review these reference documents, and there are some additional resources on slide 41.

So I know we covered that kind of in a quick fashion. We want to point out to you and remind you that if you do have questions and/or you need help, contact your EHR vendor with any technical questions or file submission errors. If your vendor is not able to answer the questions, please contact the QualityNet help desk at 866-288-8912. They're available from 7 a.m. to 7 p.m. Central Time Monday through Friday. You can also e-mail them at qnetsupport@sdps.org.

That completes my part of the discussion. I'm going to turn it over to Kim Schwartz for a brief overview of IACS.

IACS Accounts for EHR Submission

Kim Schwartz: Thanks, Dr. Green.

We'll start on slide 43, IACS accounts for EHR submission. On slide 44, individuals authorized access to CMS computer services IACS account needed for submitting, e-prescribing, and Physician Quality Reporting data via the portal. Roles are available for eligible professionals using the EHR reporting method for their Physician Quality Reporting or e-prescribing data. That includes EHR submitter and individual practitioner.

On slide 45, practices paid under an employer identification number, also known as EIN, by Medicare Part B, are considered an organization with IACS. Practices paid under an SSN by Medicare Part B are considered an individual practitioner with IACS, as well.

Slide 46, IACS organizations, we have a security official, also known as an SO. This role creates the organization, approves roles for other users, but will not have access to submit data via the portal. The SO is the first person required to register with IACS for an organization. Once the SO has a user ID for IACS, others may register for an account.

On slide 47, a backup security official: This role has the ability to approve roles for other users, but will not have access to submit data via the portal. It is not required to have a backup security official.

Moving on to slide 48, an EHR submitter, the definition, this role is part of a health care organization and is authorized to submit personally identifiable information to CMS applications. A user within an organization is not allowed to have multiple roles, and a security official/backup security official must approve the EHR submitter role, which is on slide 49.

Moving on to slide 50, for the individual practitioner, this role is required if the individual practitioner would like to submit as an EHR or as the personally identifiable information data. The provider is the only user eligible to register for this role with IACS. Once the individual practitioner account is set up, the provider may request the EHR submitter role.

On slide 51, for available resources, contact the QualityNet help desk for the following: portal password issues, Physician Quality Reporting IACS registration questions, Physician Quality Reporting IACS login issues, program- and measure-specific questions.

Our number’s located on the slide, and I will note that it’s Central Standard Time Monday through Friday 7 a.m. to 7 p.m. Or you may contact them at qnetsupport@sdps.org.

Slide 52 provides some available resources, the available guide for obtaining the security official role, obtaining the backup security official role, obtaining the individual practitioner role, obtaining the EHR submitter role, and IACS account troubleshooting issues, as well as how to find the guides that are posted on the portal at http://www.qualitynet.org/pqrs.

That concludes my part of the presentation.

Geanelle Herring: Thank you, Kim.

At this time, we will pause for just a few moments to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us here today. Please note that there may be moments of silence while we tabulate the results.

Holley, we're ready to start polling.

Holley: CMS greatly appreciates that many of you minimize the government's teleconference expense by listening to these calls together in your office using only one line. Today we would like to obtain an estimate of the number of participants in attendance to better document how many members of the provider community are receiving this valuable information.

At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number between two and eight. If there are nine or more of you in the room, enter nine. Please hold while we complete the polling.

Geanelle Herring: We will open the lines up for the Q&A session shortly, but before we begin, I'd like to remind everyone that this call is being recorded and transcribed, so please state your name and the organization you represent prior to asking your question. In an effort to get as many of your questions asked and answered as possible, we ask that you limit the number of questions you ask us to just one.

Question and Answer Session

Holley: Thank you for your participation. We will now move into the Q&A session for this call. To ask a question, press star, followed by the number one on your telephone keypad. To remove yourself from the queue, please press the pound key. Please state your name and organization prior to asking a question and pick up your handset before asking your question to assure clarity. Please note, your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference.

Please hold while we queue the roster.

Your first question comes from the line of Bettina Berman.

Bettina Berman: Hi, Dr. Green. This is Bettina Berman from Thomas Jefferson University in Philadelphia. I have a question about claims-based reporting, if I may ask that today.

The zero percent performance that does not count for the measure this year, that would be the AP modifiers or certain G-codes. Is that only if the physician submits only AP modifier codes?

Daniel Green: That's correct. Basically, imagine that an eligible professional says I didn't do a given quality action and with no particular reason, in other words, the patient wasn't allergic to the medication or there was some other compelling reason why the quality action couldn't be done. If that's the case for every single patient they're reporting on, we would construe that that measure is not likely to apply to that given eligible professional and we would want that person to select a different measure.

Bettina Berman: But if he had a performance of 75 percent, for example, it would still count. It would just be those 25 percent that would be pulled out then?

Daniel Green: If we don't pull them out — actually, you're right, they would count. And that would be fine. We're looking at reporting rates, and they would have to report if they're doing via claims more than 50 percent of the time. The key is they have to perform the clinical quality action on at least one patient.

Bettina Berman: OK, that's great. I do have a separate quick question. I was under the impression that the data for the previous years of PQRS or PQRI was available for researchers. Is that something you can help me with, to give me the information on where to find it?

Female: Are you looking for aggregate data in terms of trends?

Bettina Berman: Yes, I have the report that goes for a couple of years. But I was looking if you have anything in an Excel database, if there's anything available to researchers. I thought I heard that something would be available to researchers.

Female: Are you just looking for that same data, but in an Excel format?

Bettina Berman: Right.

Female: That's probably something we can make available.

Bettina Berman: OK.

Michael Rapp: Are you looking for all the raw data?

Bettina Berman: Yes.

Michael Rapp: We don't make that available to the public.

Female: You would have to go through our research data request processes. CMS has a research data contractor.

Michael Rapp: So there are two different things. One, if you want the results we talked about — what we publish in a PDF format — and you want to have that in Excel, if that's what you're talking about, that's easy.

Female: Right.

Michael Rapp: But if you're talking about all the claims data on which the determinations are based, that's something different.

Bettina Berman: No, I'm talking about the former.

Michael Rapp: OK. The former we could provide. Can we take down your name and your phone number?

Bettina Berman: Thanks so much. Appreciate it.

Holley: Your next question comes from the line of Cherie Hulihee.

Cherie Hulihee: This is Cherie Hulihee from Atherton Neurology and I've been asked by my providers if we want to avoid all the penalties, do the providers become non-par? Or do they opt out of Medicare altogether?

Michael Rapp: What was your question again?

Cherie Hulihee: If the providers do not want to participate in any of the programs, do they have to become non-par or opt out of Medicare altogether?

Michael Rapp: They don't have to do either one. If they don't participate in the program, they will be subject to the payment adjustment. So, for example, if you don't participate in the e-Prescribing Incentive Program, there will be a minus 1 percent. If you're non-par, it's different than if you're par, because there's an additional, I think it's 5 percent, that's taken away for not participating.

But you're not required to participate in these programs. It just means that the payment is adjusted.

Cherie Hulihee: But if they wanted to avoid all the payment adjustments and everything, they'd have to opt out of Medicare altogether?

Michael Rapp: Well...

Female: In terms of not billing Medicare, is that what you're asking?

Cherie Hulihee: Yes.

Michael Rapp: If you're not enrolled in Medicare, then you don't get any payments. You'd get zero. This is the difference between getting 100 percent and 99 percent as opposed to zero. You would not be subject to the penalty, if you will, or payment adjustment, but on the other hand, the beneficiary would not be able to have services paid for by Medicare at all.

Cherie Hulihee: Correct. I've just been asked this question, and it's a very small office and it's becoming overwhelming having to get this all together.

Michael Rapp: Well, on the other hand, you could just accept the payment adjustment, if you will. It will just be automatically reduced. There will be a slight reduction in the payment to the professional, and there would be a slight adjustment in terms of less co-pay to the beneficiary.

Cherie Hulihee: OK. I'll let them know. Thank you.

Michael Rapp: Thank you.

Holley: Your next question comes from the line of Maria Tiberend.

Maria Tiberend: Hi, my name is Maria Tiberend with BJC Medical Group in St. Louis, Missouri. My question is regarding the e-prescribing incentive or penalty for 2013. Knowing that we're coming up on the end of December and we're submitting our G-codes when appropriate, I have not heard anything about potential exemptions to avoid the 2013 penalty for physicians who may not have enough e-prescribing events. Can you speak to whether we'll have that opportunity to submit exemptions for those services in these last six months of the year to avoid the 2013 penalty, and what sort of timeframe?

Female: We discuss that in the 2012 physician fee schedule final rule. In that rule, we also finalized a second reporting period for the 2013 payment adjustment, so if you don't successfully report the e-prescribing measure 25 times before the end of this year, you do have a second opportunity to meet the requirements in the first six months of 2012. If you successfully report the e-prescribing measure 10 times in the first six months of 2012, you can avoid the 2013

payment adjustment; or, we finalized four different hardship exemption categories for the 2013 payment adjustment.

They were: inability to electronically prescribe due to State, local, and Federal law regulations; fewer than 100 prescriptions in a 6-month period; insufficient pharmacies that are able to accept electronic prescribing; and in a rural area that doesn't have high-speed Internet access. Also, the same automatic exclusions that we had for the 2012 payment adjustment apply for the 2013 payment adjustment. If you're not an MBBO, podiatrist, nurse practitioner, or physician assistant, you're not subject to the payment adjustment if you didn't bill the measures denominator 100 times in the first six months of 2012, you're not subject to a payment adjustment. If less than 10 percent of your charges are comprised of the codes in the measure's denominator, you won't be subject to the 2013 payment adjustment as well.

Maria Tiberend: Right. OK, and this was published in the Federal Register?

Female: Yes, in the 2012 Physician Fee Schedule.

Maria Tiberend: In the fee schedule? And it's already approved? It's not just proposed?

Female: Correct.

Maria Tiberend: OK, I appreciate the information. Thank you.

Holley: Your next question comes from the line of Alison Kossuth.

Alison Kossuth: Hi, this is Alison Kossuth from Spectrum Health. On slide 8, they talk about the registry methods of data collection, and one of the things that's listed there is EHR. This is the method that we've used in the last two years, and our vendor that we've been doing this with has told us that they're not going to be able to do that for 2012.

I think the comment is something about bidding for vendors who collect data directly from an EHR from submitting PQRS data using registry submission. And I'm just wondering if that is something that's coming in 2012 or if we're getting wrong information.

Daniel Green: You're getting half information. Vendors that receive their information only via an EHR would need to apply to become, quote, unquote, "data submission vendors" for 2012. For 2012, there are 51 electronically specified measures, and they could report any of those 51 measures on an eligible professional's behalf.

If the EP is also using an ONC-certified system, they could report the measures currently as they do in an XML format three core plus three other measures; or, if the core measures have zeroes in any one of them, they'd have to report up to three alternate cores. But they could report that in the XML format, and then they could actually use that same data and send it to us — this is the vendor, now — in the QRDA level one, so the individual data elements or components of the measure are the patient's file for the measure.

And the eligible professional would qualify for both the PQRS incentive, as well as the meaningful use clinical quality measure requirement. So, you know, for meaningful use, there are 15 menu items that folks have to do. One of which is the clinical quality measures. Plus, I think you have to pick 5 more out of an additional 10 optional ones.

This would meet the clinical quality measure requirement, as well as PQRS, if it's reported through a qualified data submission vendor. Again, of course, this is assuming you're using an ONC-certified system.

Alison Kossuth: OK, so I understood about half of that.

Daniel Green: OK. What can I clarify for you?

Alison Kossuth: Well, did you say they can report on 51 measures?

Daniel Green: That's correct. There are currently 51 electronically specified measures for 2012. They're limited in terms of being able to report those 51 measures, if they're a data submission vendor.

Alison Kossuth: OK. So it sounds like I need to get back to my vendor.

Daniel Green: Yes, what kind of practice are you?

Alison Kossuth: It's a multiple-provider practice.

Daniel Green: OK, I mean, clearly for your primary care folks, these measures would be fine, there are some other measures of the 51 that other types of providers also could report, or they could report as a group practice reporting in the future, as well.

Alison Kossuth: And they can do that, the group you said?

Daniel Green: They could self-nominate to be a GPRO in 2012.

Alison Kossuth: OK. My other question is—at the very beginning, there were some updates given, and it was mentioned that there was not going to be a feedback report. Does that mean that the providers won't know if they're subject to a payment adjustment until they actually see it on their remittance advices?

Female: We are looking at other ways to notify the eligible professionals, but, yes, it will show up on your remittance advice, so look for that in January 2012.

Alison Kossuth: That was with an LE code?

Female: Yes, LE code, and we also have a Medicare Learning Matters article out. If you want go to our e-prescribing Web site, and go to educational resources when you're on that page, there's a link for the article, and it's the MLN Matters article SE, special edition, 1141. That has the details on what to expect in terms of what your remittance advice will look like and the codes that will be used.

Alison Kossuth: Is there anything in there about if they see a payment adjustment and they don't think that it's accurate?

Female: Yes.

Alison Kossuth: "An error," I think that's how it was worded.

Female: Right, yes. You can contact your Carrier MAC, and there are instructions included in that article.

Alison Kossuth: OK, great. Thank you so much.

Female: You're welcome.

Holley: Your next question comes from the line of Jennifer Montgomery.

Jennifer Montgomery: Hi, my name is Jennifer Montgomery from Beth Israel Medical Center here in New York. I'm a little confused from the call about the vendors' data submission in ONC. I'm getting a little confused between PQRS and the meaningful use core measures. When they start to do meaningful use, can they do both PQRS and meaningful use within the same measures group? I realize that meaningful use seems to be pointed predominantly to primary care physicians. How are the specialists going to fit into that realm?

Daniel Green: Let me tackle your first question. In 2012, we have a pilot program that we have in the EHR incentive/PQRS program, whereby an eligible professional can report directly from their ONC-certified/PQRS-qualified EHR into CMS. And they would need to report the three ONC core measures, plus three additional of the remaining 44 measures.

Again, you'll hear me say on the call the three plus three plus three. What I mean by that is the three core measures and/or if any of those have a denominator of zero — in other words, no patients in them — they would need to report for one of the alternate core measures. So, if there were two core measures that had zeroes in the denominator, they would need to report two alternate core measures as well.

It could be that they have to report a total of nine measures, the three core (with the zero), the three alternate core, plus three additional. That's what I mean by the three plus three plus three. These are the HITECH reporting requirements for clinical quality measures.

In any case, if an eligible professional has a PQRS-qualified system and an ONC-certified system, they could report this three plus three plus three

directly from their EHR into our CMS portal, and they would meet the clinical quality measure requirement for the meaningful use program, as well as earn a PQRS incentive payment. So, with one reporting, basically, they would meet two requirements.

Alternatively, they could use a qualified data submission vendor, and we're just getting self-nominations for these folks now. If a data submission vendor becomes qualified for PQRS and the provider's using an ONC-certified system, they could use their ONC-certified system to report their information to the data submission vendor, who in turn would report the three plus three plus three to CMS in an aggregate form using one specification and, at an individual level, using a different specification. But it would be the same data, basically.

Again, then the provider would qualify for a PQRS incentive payment and they would meet the clinical quality measure metric under the meaningful use requirements. So it's a nice way for eligible professionals to reduce the burden. At the same time, we're trying to align the two programs as is required by the Affordable Care Act, which was passed in 2010.

As to your question about specialties being able to report, we are considering expanding the measures so that they would be more applicable to some of the specialties, but that would be the subject of future rulemaking.

Jennifer Montgomery: OK, thank you so much.

Daniel Green: Thank you. I hope that cleared it up for you. It takes a little bit of time to try to sort through it.

Jennifer Montgomery: Yes. Thanks.

Daniel Green: Thank you.

Holley: Your next question comes from the line of Jaimee Shelton.

Jaimee Shelton: Hi, good afternoon. My name is Jaimee Shelton. I'm calling from South Florida Radiation Oncology. If you can, I would like you to discuss more in

regard to the eRx for radiation oncologists, for us not meeting the denominator because the denominator we would report is procedure code 77427 rather than an E&M service. So, I'm asking if radiation oncologists are automatically exempt from the penalization?

Daniel Green: Do your doctors ever bill one of those E&M service codes?

Jaimee Shelton: They do, but what happens is that when they bill the E&M service codes, according to Medicare, we can only bill it 90 days after they've administered radiation therapy to a patient. Normally we do not prescribe any prescriptions during that time period. Most of the prescriptions are normally done throughout the course of radiation, throughout the seven to eight weeks, and our denominator that we report is the weekly management code, the 77427. But that's not part of the eligible denominators.

Daniel Green: So basically, if you report less than 100 of the E&M codes that are in the denominator of the measure in the first six months of 2011, you would not be subject to the payment adjustment in the first place. If less than 10 percent of your total charges are comprised of those codes, meaning the E&M codes and the denominator measure, as compared to your overall total charges to Medicare, you also would be eliminated from the denominator of the measure.

Jaimee Shelton: OK, perfect. This has been a topic we have never been able to get clarified because we don't fall under the hardship. OK, thank you for clarifying that for me.

Daniel Green: Sure, you're welcome.

Holley: Your next question comes from the line of Debra Anderson.

Debra Anderson: Yes. We've been doing PQRS for several years, and my only question is, next year, do we have to pick different measures to report on? Or can we continue to do the same measures?

Daniel Green: Which method have you been using?

Debra Anderson: Claim-based.

Daniel Green: Occasionally, we retire measures from PQRS for one reason or another. Perhaps the measure owner retires the measure or whatever. We would just encourage you to check the 2012 measure list that's posted. Also, just check the measures quickly to make sure there haven't been any changes. Occasionally there are some minor coding changes from year to year, and we would want you to make sure you're reporting the proper codes.

Debra Anderson: OK, thank you very much.

Daniel Green: Thank you.

Holley: Your next question comes from the line of Jennifer Aquilar.

Jennifer Aquilar: Hi, my name is Jennifer Aquilar, and I'm calling from Aquilar Foot Care Clinic in Arkansas. My first question is regarding the e-prescription hardship situation that was going on. When some of the updates were given right in the beginning, they alluded to the e-mail that was sent out that needed clarification.

I also participated in the call last week and [someone] tried to help me. I have not heard anything since. We are a one-doctor podiatric office, and I filed for our hardship exemption back on September 29th. I spoke with QualityNet help desk twice before the November 8 deadline. And not once did they inform me — even though I had reviewed with them which NPI I put on the communication support page — that we had to send in for the exemption application process.

I've let them know everything I did. Every time they pulled out my application, they said everything was good to go. I was in line for processing, because I was trying to be very diligent, do as much reading as I could to make sure this went through fine.

We have registered. I applied under the EHR hardship exemption. We have our EHR-certified technology. We just haven't gone live yet. We're still in the process of setting it up.

I called twice since the hardship exemption deadline passed to QualityNet help desk, just to make sure everything was still in line, that we hadn't gotten lost somewhere. They told me I was fine, until December 1, when I called, my fourth phone call, they pulled up the same NPI that they had pulled up the previous three phone calls and said, "Oh my gosh, you have your clinic NPI in here next to your clinic Tax ID number, instead of the individual doctor's NPI." And I said, "Well, you know, I've been over this with you guys the previous three phone calls. You told me that was fine. If you would have told me in the first two phone calls, I could have fixed it before the deadline. It's not like I haven't tried to pay attention to what's going on."

There are numerous programs out there. It's very hard for us as providers to keep up with all the different programs and the changes. We're doing the best we can, and I'm sure many can feel the same way I do about that.

When they pointed out the error on December 1, they said, "You know what, they'll probably deny your hardship exemption, because it's going to pull the clinic up as not being someone who qualifies. However, your doctor is the only one affiliated with that clinic. You are one of thousands who are calling us with this same problem. We're hoping CMS comes up with some kind of corrective process, because a lot of people, due to the vagueness of the support page that you filled out to submit your information, it didn't say individual NPI. It just said NPI right next to your legal business name and business Tax ID."

They were hoping there would be some kind of corrective process put into place, and they asked me to go ahead and submit a question to CMS via the CMS Web site, which I did. Back on December 2, I was assigned a number to my question. I've never heard anything since. I cannot get anyone to talk to me about this and QualityNet help desk is the only contact that CMS gives, and they say it's a huge problem, but yet my physician is in line to unfairly be penalized.

Elia Cossis: This is Elia Cossis. Could I get your phone number and your name? I will directly reach out to you.

Jennifer Aquilar: OK. I appreciate it. Thank you.

Elia Cossis: OK.

Holley: And your next question comes from the line of Michelle Carabin.

Michelle Carabin: Hi, I have physicians that I'm going to be signing up for the meaningful use, and my understanding is that if they're doing the meaningful use, that that would be considered valid versus having to do e-prescribe over again. Am I correct with that?

Daniel Green: Speak up just a little bit. We're having a hard time hearing you here. You're signing up for meaningful use. We got that part.

Michelle Carabin: Right. So my understanding was that the meaningful use — if they're doing meaningful use for 2012, do they still need to submit the e-prescribe 6-month statistics in order to be exempt for 2013?

Female: Yes, you would still need to separately report the e-prescribing measure to avoid the 2013 payment adjustment.

Michelle Carabin: They modified it this year, obviously. Why wouldn't they modify it each year? It's the same physicians that protested it for this year and they will protest it again.

Female: This year was a special circumstance because the requirements for the EHR technology and the timing of when our requirements for the e-prescribing payment adjustment were not released soon enough, so that some physicians or professionals may have had to buy two different e-prescribing systems or EHRs to participate in both programs because of the timing of when the two programs' requirements were released.

But this is now the second year of the meaningful use program, as well as the second year of e-prescribing payment adjustment that would no longer be a hardship.

Now, we've also further aligned the programs by stating that you can just use your EHR system that you purchased or have acquired for meaningful use for purposes of e-prescribing programs. So the only thing that you would need to do is report to us that you have e-prescribed at least 10 times.

Michelle Carabin: OK. And was all of that other stuff that you went over today that I didn't understand at all?

Female: We did not go over that today.

Michelle Carabin: OK.

Female: We went over it last month.

Michelle Carabin: Oh, I listened to last month's call. I'm having a problem finding any of the downloaded forms, the presentations. I'm not receiving any e-mails to be able to download, and then I'm not able to download them. This one I actually got today, but the last one that I listened to, I couldn't download anything. Is that list available anywhere for me to refer to?

Female: It's on the PQRS Web site, but on the CMS Sponsors Call page.

Michelle Carabin: OK. I don't know what the PQRS Web site means to me.

Female: OK, www.cms.hhs.gov/pqrs.

Michelle Carabin: PQRS. OK, so when I go there, where else do I go?

Female: And then you go to the left-hand side, and there will be some section pages, and it'll be probably the third one down. It'll say CMS Sponsors Call page.

Michelle Carabin: OK.

Female: And then you'll click that link, and then you'll scroll down to the Download section, and it'll be the second download. It'll say "Previous National Provider Call Presentation." And it'll be in that file.

Michelle Carabin: OK, I'll read through it there.

Female: OK.

Michelle Carabin: Just a suggestion — this seems like an awful lot of extra administrative work for the physician, when they already make the effort to do meaningful use and submit the statistics for that. So I don't understand why Medicare feels the need to wham the doctor twice for e-prescribe when he is making an effort to follow, you know, the whole process for e-prescribe.

Michael Rapp: Well, on that, it has to do with how the Congress passes legislation. So when passing the EHR incentive program, they didn't deal with the e-prescribing penalty. But what we've tried to do in implementing the program is make it as absolutely easy as possible to avoid the penalty. So for 2012 reporting, to avoid the payment adjustment, in the first six months, you only have to report 10 times.

Michelle Carabin: Right, but we're orthopedic surgeons so 99 percent of the medications we dispense are narcotics, so the Federal government has not yet forced the States to allow us to prescribe narcotics electronically, so we're penalized there. And then, you know, I have to force my doctors to give out medication for 10 patients when they don't normally give out medications so arbitrarily like that. So you're forcing the doctor to perform medicine that they don't want to perform, because they have to meet a 10 person statistic.

And that was the complaint for last year as well. It wasn't a matter of, "I have to purchase this EHR system and I found out at the last minute." It was the fact that you've got orthopedic surgeons and other physicians who don't prescribe on a regular basis like that.

Michael Rapp: Yes, well, hopefully, we're certainly not trying to induce people to prescribe when they wouldn't otherwise do it.

Michelle Carabin: But you are.

Michael Rapp: Well, there's an exemption if you prescribe less than 100 prescriptions that are non-narcotics. So that's a hardship exemption you can apply for.

Michelle Carabin: That's based on E&M codes, so my doctors see more than 100 patients.

Michael Rapp: Oh, no, it's based upon you indicating that they do less than 100 prescribing events. You just indicated that they rarely prescribe anything.

Michelle Carabin: Is that Medicare only? Or is that all patients?

Michael Rapp: Well, yeah, it has to do with Medicare, because that's what we're talking about. It's less than 100 prescribing events. That's a hardship — that's a new hardship category you can put in. It doesn't have anything to do with billing codes or anything like that. If what you say is accurate, then you just apply for the hardship.

Female: In addition, there's also the hardship exemption for people who primarily prescribe controlled substances. That falls under the inability to electronically prescribe due to State, local, Federal law, and regulation.

Michelle Carabin: That's last year's exemption, because that wasn't part of it last year, until they revised it in November. Those exemptions carry over again into this year.

Female: That particular one does carry over.

Michelle Carabin: All right. Then I didn't hear that part. I apologize. Thank you.

Female: Thank you.

Holley: Your next question comes from the line of Natasha Bradley.

Renee: Hi, there. Actually, I'm attending with Natasha. My name is Renee. I'm calling from Shenandoah Valley Surgical in Fishersville, Virginia.

Our physicians submitted the e-prescription hardship exemption and received the letter that was discussed in the first part of the call. Can you please repeat what the letter was intended to mean regarding the difference in the NPI numbers?

And then second, if we've received confirmation from QualityNet, after the letter was received, that our doctors won't receive the penalty, can we be confident with that answer?

Female: Regarding your first question about the clarification; basically, the individual TIN/NPI combination you submitted did not match any TIN/NPI combination on the payment adjustment file.

Renee: OK.

Michael Rapp: So you called the help desk, correct? And the help desk said that you would not be subject to the payment adjustment?

Renee: That's right. After this e-mail letter was received, we e-mailed the QualityNet help desk with the NPI numbers, just to confirm that the physicians would not be subject to the penalty, and they confirmed that they were not.

Michael Rapp: So you can be very confident that that is correct.

Renee: But now that I hear this about the letter and the TIN/NPI combinations not matching up, I'm concerned.

Michael Rapp: Well, did you use the individual NPI?

Renee: When I e-mailed the QualityNet help desk, yes, we used the individual physician's NPI numbers.

Michael Rapp: OK. Then you are OK. You can be confident in your answer from the help desk in that case.

Renee: OK. Thank you.

Michael Rapp: Thank you.

Geanelle Herring: Holley, we have time for just one more question.

Holley: OK. Your next question comes from the line of Karen Bragg.

Karen Bragg: Hi, this is Karen Bragg with Eastern Maine Medical Center in Bangor, Maine. I'm looking for clarification on one item with the eRx program in regards to the incentive versus the payment adjustments. Some of our providers didn't actually make the required 10 that were supposed to be met by June 30th. However, they have easily made their 25 that were due by the end of December already. Is it true that, if they don't make their June deadline, they are exempt then from the incentive payment also?

Female: The incentive payment calculations and the payment adjustment calculations are completely separate.

Karen Bragg: OK. All right. Thank you very much.

Female: Thank you.

Geanelle Herring: We'd like to thank everyone for joining us here today and for your participation in the question-and-answer portion of the call. The audio file and transcript of today's call will be made available shortly at http://www.cms.gov/pqrs on the CMS Web site. If you were unable to ask your question of the CMS subject matter experts gathered here today, please feel free to contact the QualityNet help desk at 866-288-8912.

On behalf of everyone here at CMS, we wish you all a happy holiday. Thank you.

Holley: Thank you for participating in today's conference call. You may now disconnect.

END